		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016949

Facility Name: St Clara's Manor

Address: 200 Fifth Street (Number) Lincoln (City) 61701 (Zip Code)

County: Logan

Telephone Number: (217)735-1504 **Fax #** ( )

IDPA ID Number: 376075710001

Date of Initial License for Current Owners: 1972

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) CRAIG L. ATER, Senior Vice President -- Finance
(Firm Name & Address) Heritge Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,850	17,305	2,444	37,599	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	17,850	17,305	2,444	37,599	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.58%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 1972 NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,444

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	267,146	20,631		287,777		287,777		287,777			1
2	Food Purchase		184,436		184,436		184,436		184,436			2
3	Housekeeping	121,145	28,468		149,613		149,613		149,613			3
4	Laundry	68,583	10,068		78,651		78,651		78,651			4
5	Heat and Other Utilities			103,813	103,813		103,813		103,813			5
6	Maintenance	53,056	44,556	32,772	130,384		130,384		130,384			6
7	Other (specify):*											7
8	**TOTAL General Services**	509,930	288,159	136,585	934,674		934,674		934,674			8
	B. Health Care and Programs											
9	Medical Director			600	600		600		600			9
10	Nursing and Medical Records	1,251,684	98,845	142,185	1,492,714		1,492,714		1,492,714			10
10a	Therapy		50,696	135,293	185,989	(57,440)	128,549		128,549			10a
11	Activities	74,662	5,849		80,511		80,511		80,511			11
12	Social Services	28,496	44	6,657	35,197		35,197		35,197			12
13	Nurse Aide Training	6,049	165		6,214		6,214		6,214			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,360,891	155,599	284,735	1,801,225	(57,440)	1,743,785		1,743,785			16
	C. General Administration											
17	Administrative	54,041			54,041		54,041		54,041			17
18	Directors Fees											18
19	Professional Services			256,026	256,026		256,026	(538)	255,488			19
20	Dues, Fees, Subscriptions & Promotions			102,795	102,795	(76,650)	26,145	(14,068)	12,077			20
21	Clerical & General Office Expenses	91,578	12,638	14,652	118,868		118,868		118,868			21
22	Employee Benefits & Payroll Taxes			366,763	366,763		366,763		366,763			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			3,544	3,544		3,544	(1,545)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			97,661	97,661		97,661		97,661			26
27	Other (specify):*			25,855	25,855		25,855	(25,821)	34			27
28	**TOTAL General Administration**	145,619	12,638	869,295	1,027,552	(76,650)	950,902	(41,972)	908,930			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,016,440	456,396	1,290,615	3,763,451	(134,090)	3,629,361	(41,972)	3,587,389			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Clara's Manor #0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			137,062	137,062		137,062	5,019	142,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,066	3,066		3,066	(3,066)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,096	1,096		1,096	(226)	870			35
36	Other (specify):*											36
37	**TOTAL Ownership**			141,224	141,224		141,224	1,727	142,951			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					57,440	57,440		57,440			39
40	Barber and Beauty Shops			8,730	8,730		8,730		8,730			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			8,730	8,730	134,090	142,820		142,820			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,016,440	456,396	1,440,569	3,913,405		3,913,405	(40,245)	3,873,160			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(226)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,019	30		9
10	Interest and Other Investment Income	(3,066)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(80)	20		17
18	Fines and Penalties	(1,300)	27		18
19	Entertainment	(1,545)	24		19
20	Contributions	(200)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(538)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,321)	27		24
25	Fund Raising, Advertising and Promotional	(13,988)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,245)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (40,245)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

St Clara's Manor

ID# 0016949

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(226)	35	5
6			0	34	6
7			0		7
8			0		8
9			5,019	30	9
10				32	10
11			0		11
12			0		12
13			0	2	13
14			0	32	14
15			0	33	15
16			0	24	16
17			(80)	20	17
18			(1,300)	27	18
19				24	19
20			(200)	27	20
21			0		21
22			(538)	19	22
23			0		23
24			(24,321)	27	24
25			(13,988)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
32					32
33			0	33	33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(35,634)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(538)	0	0	0	0	0	0	0	0	0	0	(538)	19
20	Fees, Subscriptions & Promotions	(14,068)	0	0	0	0	0	0	0	0	0	0	(14,068)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,545)	0	0	0	0	0	0	0	0	0	0	(1,545)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(25,821)	0	0	0	0	0	0	0	0	0	0	(25,821)	27
28	**TOTAL General Administration**	(41,972)	0	0	0	0	0	0	0	0	0	0	(41,972)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,972)	0	0	0	0	0	0	0	0	0	0	(41,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,019	0	0	0	0	0	0	0	0	0	0	5,019	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,066)	0	0	0	0	0	0	0	0	0	0	(3,066)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(226)	0	0	0	0	0	0	0	0	0	0	(226)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,727	0	0	0	0	0	0	0	0	0	0	1,727	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,245)	0	0	0	0	0	0	0	0	0	0	(40,245)	45

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V		10a				100.00%			2
3	V									3
4	V		19				100.00%			4
5	V									5
6	V		10a				100.00%			6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$		100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	0	100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Clara's Manor COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0016949

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 38,660	1
2					2
3	TOTALS			$ 38,660	3

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140				$ 1,624,882	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976			1976	65,361						9
10	1978			1978	3,451						10
11	1980			1980	8,793						11
12	1981			1981	11,439						12
13	1982			1982	3,826						13
14	1983			1983	1,535						14
15	1984			1984	4,031						15
16	1985			1985	7,859						16
17	1986			1986	2,541						17
18	1987			1987	10,753						18
19	1988			1988	1,006						19
20	1989			1989	1,431						20
21	1991			1991	8,799						21
22	1992			1992	17,963						22
23	1993			1993	15,564						23
24	1994			1994	51,022						24
25	1995			1995	124,932						25
26	1996			1996	102,380						26
27	1997			1997	39,247						27
28	Fire Sprinkler			1998	22,151						28
29	Transfer Switch			1998	4,819						29
30	Water Line			1998	6,379						30
31	Soffits			1998	3,950						31
32	Generator			1998	3,164						32
33	Heating, A/C Improvements			1998	8,664						33
34	C/O Allocation										34
35	Book Depreciation					72,739		78,294	5,555	1,681,179	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Windows	1998	$ 3,422	$		$	$	$	37
38	Sidewalks	1998	2,963						38
39	Fixtures	1999	224						39
40	Faucets	1999	1,532						40
41	Water System Improvements	1999	7,920						41
42	Windows	1999	23,400						42
43	Fixtures	1999	2,812						43
44	Faucets	1999	1,404						44
45	Heating & Cooling Unit	2000	4,050						45
46	Water System	2000	37,203						46
47	Glass Doors	2000	1,145						47
48	Remodeling	2000	4,581						48
49	Plumbing	2000	4,128						49
50	Windows	2000	600						50
51	Plumbing	2000	1,702						51
52	4 Ton Condensing Unit	2000	4,453						52
53	Windows	2000	5,400						53
54	Exhaust Fan	2000	1,100						54
55	Heating & Cooling Units	2000	4,050						55
56	Doors	2000	4,081						56
57	Porch Ceiling	2000	4,050						57
58	Exhaust Fan	2000	2,046						58
59	Concrete Pad	2000	5,398						59
60	Fire Sprinkler	2001	1,304						60
61	Faucets	2001	3,432						61
62	Patio Roof	2001	1,532						62
63	Exhaust Fan	2001	1,000						63
64	A/C Unit	2001	16,312						64
65	A/C Kitchen	2001	6,850						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,314,036	$ 72,739		$ 78,294	$ 5,555	$ 1,681,179	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,314,036	$ 72,739		$ 78,294	$ 5,555	$ 1,681,179	1
2									2
3	Code Alert Alarm	2002	5,600						3
4	Ceiling Fan	2002	996						4
5	Heat Cool Units	2002	4,550						5
6	Carpet	2002	2,361						6
7	Seal Coat Parking Lot	2002	3,342						7
8	Walk-In Cooler	2002	17,518						8
9	Roof Replacement	2002	92,577						9
10	Door	2002	824						10
11	Wide Area Network Wiring	2002	3,167						11
12		2002							12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,444,971	$ 72,739		$ 78,294	$ 5,555	$ 1,681,179	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,024,725	$ 54,932	$ 54,396	$ (536)		$ 710,579	71
72	Current Year Purchases	11,417						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,036,142	$ 54,932	$ 54,396	$ (536)		$ 710,579	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 19,814	$ 9,391	$ 9,391	$		$ 37,319	76
77				54,279						77
78										78
79										79
80	TOTALS			$ 74,093	$ 9,391	$ 9,391	$		$ 37,319	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,593,866	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,062	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,081	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,019	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,429,077	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 870 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		165		165
3	Classroom Wages (a)		6,049		6,049
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 6,214	$	$ 6,214
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,214			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 47,062	$		$ 47,062	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			5,392			5,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			74,476	1,619		76,095	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				49,077		49,077	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				8,363			8,363	13
14	TOTAL			$		$ 135,293	$ 50,696		$ 185,989	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 608,877	$	1
2	Cash-Patient Deposits	9,605		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	484,989		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,674		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(103,214)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,031,931	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,863		13
14	Buildings, at Historical Cost	2,407,206		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,120,796		16
17	Accumulated Depreciation (book methods)	(2,302,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Tax Asset			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,291,337	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,323,268	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 192,757	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,605		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,798		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,851		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	19,320		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 283,331	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	139,212		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 139,212	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 422,543	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,900,725	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,323,268	$	48

***(See instructions.)**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,781,311	1
2	Restatements (describe):		2
3	**Audit Adjustment**	(48,996)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,732,315	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	168,410	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 168,410	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,900,725	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,113,080	1
2	Discounts and Allowances for all Levels	(426,446)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,686,634	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	268,840	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 268,840	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,492	12
13	Barber and Beauty Care	13,779	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 112,620	23
	D. Non-Operating Revenue		
24	Contributions	9,106	24
25	Interest and Other Investment Income***	4,615	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,721	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,081,815	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	934,674	31
32	Health Care	1,801,225	32
33	General Administration	1,027,552	33
	B. Capital Expense		
34	Ownership	141,224	34
	C. Ancillary Expense		
35	Special Cost Centers	8,730	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss from Non-Nursing property		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,913,405	40
41	**Income before Income Taxes (line 30 minus line 40)****	168,410	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 168,410	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,144	$ 62,975	$ 29.37	1
2	Assistant Director of Nursing	656	664	19,366	29.17	2
3	Registered Nurses	2,412	2,597	49,428	19.03	3
4	Licensed Practical Nurses	24,373	26,050	394,253	15.13	4
5	Nurse Aides & Orderlies	69,658	73,371	686,651	9.36	5
6	Nurse Aide Trainees	750	750	6,049	8.07	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,089	5,625	39,011	6.94	8
9	Activity Director					9
10	Activity Assistants	8,562	9,223	74,662	8.10	10
11	Social Service Workers	1,943	2,000	28,496	14.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,291	37,188	267,146	7.18	15
16	Dishwashers					16
17	Maintenance Workers	5,742	6,215	53,056	8.54	17
18	Housekeepers	16,941	18,038	121,145	6.72	18
19	Laundry	8,913	9,890	68,583	6.93	19
20	Administrator	2,080	2,080	54,041	25.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,316	7,993	91,578	11.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,742	203,828	$ 2,016,440 *	$ 9.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		600		36
37	Medical Records Consultant		5,350		37
38	Nurse Consultant				38
39	Pharmacist Consultant		500		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		6,657		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,107		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 3,599		50
51	Licensed Practical Nurses		54,745		51
52	Nurse Aides		74,891		52
53	TOTAL (lines 50 - 52)		$ 133,235		53

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Keith Fisher	Administrator	0	$ 54,041
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,041

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 243,974
Abbott & Assoc	Accounting	11,214
		0
Health Services	Consulting	300
Various	Legal	538
Legal Fees (Adjusted to zero)		0
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 256,026

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,949
Unemployment Compensation Insurance	9,718
FICA Taxes	154,258
Employee Health Insurance	105,047
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	76,791
Employee Benefits - central office	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 366,763

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	3,287
Health Care Worker Background Check	
(Indicate # of checks performed 30)	315
Central Office Allocation	0
Promotional Advertising	8,153
Public Relations	5,835
Dues and Subscriptions	7,715
License and Fees	840
Less: Public Relations Expense	(5,835)
Non-allowable advertising	(80)
Yellow page advertising	(8,153)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,077

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	241
	43
Seminar Expense	3,260
Non Allowable	(1,545)
Central Office Allocation	0
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Clara's Manor **#** 0016949 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Abbott & co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount							
1009			PETTY CASH	608,877							1,009	608,877				
1010			CASH IN BANK								1,100	484,989				
1040			CASH IN BANK-PAYROLL								1,101					
1100			ACCOUNTS RECEIVABLE	484,989							1,110					
1110			MEDICARE RECEIVABLES								1,125					
1125			IPA INCOME RECEIVABLE								1,135					
1130			MEDICARE COST REPORT								1,140					
1135			ACCOUNTS RECEIVABLE-IC								1,145					
1140			UNAPPLIED CASH RECEIPTS								1,200	31,674				
1145			A/R SUSPENSE-REFUNDS								1,220					
1190			ACCRUED INTEREST REC								1,300					
1200			PREPAID INSURANCE	31,674							1,310					
1220			OTHER PREPAID EXPENSES								1,320					
1300			FOOD INVENTORY								1,409	65,863				
1310			SUPPLIES INVENTORY								1,450	1,120,796				
1409			LAND	65,863							1,460	-748,430				
1450			FURNITURE & EQUIPMENT	1,120,796							1,475	2,407,206				
1460			ACCUM DEPR-FURN & EQUIP	-748,430							1,490	-1,554,098				
1475			BUILDING & IMPROVEMENTS	2,407,206							1,530	9,605				
1490			ACCUM DEPR-BUILDING	-1,554,098							1,550					
1530			RESIDENT FUNDS	9,605							1,551					
1550			LOAN FEES	0							1,850	-103,214				
1560			REAL ESTATE TAX ESCROW								2,010	-192,757				
1575			REIMBURSABLE PURCHASES								2,100	-56,798				
1850			INTRACOMPANY	-103,214							2,100					
2010			ACCOUNTS PAYABLE	-192,757							2,100					
2095			BONUSES PAYABLE								2,100					
2100			ACCRUED PAYROLL	-56,798							2,110	0				
2110			ACCRUED VACATION PAY	0							2,120					
2120			UC TAXES PAYABLE								2,125					
2125			FICA TAX PAYABLE	-4,851	-4,851						2,130	-4,851				
2130			FIT PAYABLE								2,140					
2140			STATE W/H PAYABLE		0						2,152					
2145			EARNED INCOME CREDIT								2,225					
2150			UC FED CREDIT REDUCTION								2,230					
2230			PAYROLL SAVINGS								2,235					
2235			IRA W/HOLDINGS								2,240					
2240			UNITED WAY								2,246					
2245			GROUP INSURANCE PAYABLE								2,250					
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260					
2260			WAGE GARNISHMENTS								2,300					
2280			MISC PAYROLL DEDUCTIONS								2,320	-19,320				
2300			ACCRUED INTEREST PAYABLE	0							2,350					
2310			SALES TAX PAYABLE								2,385					
2320			IPA PAYMENTS PAYABLE	-19,320							2,400					
2350			REAL ESTATE TAX PAYABLE	0							2,512	-9,605				
2385			ACTIVITY FUND	0							2,600	-139,212				
2390			SECURITY DEPOSITS								2,600					
2391			VOLUNTEER FUND								2,625					
2393			HEART FUND/BAZAAR								2,625					
2395			DEFERRED INC EMP & MEM								2,695					
2400			CURRENT PORTION LT DEBT								2,720	-1,732,315				
2460			INCOME TAXES PAYABLE									-168,410				
2512			DUE TO RESIDENTS	-9,605												
2600			MORTGAGE PAYABLE	-139,212												
2650			EQUIPMENT LOAN PAYABLE								balance	0				
2695			CURRENT PORTION LT DEBT													
2696			DEFERRED INCOME TAXES													
2710			COMMON STOCK													
2720			RETAINED EARNINGS	-1,732,315												
2970			PROFIT/LOSS FOR PERIOD	-168,410												
3007.1			PATIENT DAYS-PRIVATE	17,502									3,007	3,007 PATIENT I	17,502	
3007.2			PATIENT DAYS-IPA	17,850									3,007	3,007 PATIENT I	17,850	
3007.3			PATIENT DAYS-MEDICARE	2,444									3,007	3,007 PATIENT I	2,444	
3007.4			PATIENT DAYS-CONVERSION										3,007			
3007.5			PATIENT DAYS-LICENSED										3,007			
3007.6			PATIENT DAYS-TOTAL										3,007			
3010		1	BASIC CHARGE-PRIVATE & VA	-2,040,691		0	0	0	0				3,007			
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0				3,010		-2,040,691	
3020		1	BASIC CHARGE-IPA	-1,292,212		0	0	0	0				3,020		-1,292,212	
3030		1	BASIC CHARGE-MEDICARE	-662,837		0	0	0	0				3,030		-662,837	
3035		4	DAY CARE/HOME CARE			0	0	0	0				3,040			
3040		1	LIGHT NURSING CARE	0		0	0	0	0				3,050			
3050		1	MEDIUM NURSING CARE			0	0	0	0				3,060			
3060		1	HEAVY NURSING CARE			0	0	0	0				3,061			
3061		1	SKILLED NURSING CARE										3,080		-102,515	
3080		1	NURSING SUPPLIES-PRIVATE	-102,515		0	0	0	0				3,081			
3081		1	NURSING SUPPLIES-IPA			0	0	0	0				3,082			
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0				3,083			
3083		1	NURSING SUPPLIES MED PT B										3,100		-97,349	
3100		17	DRUGS	-97,349		0	0	0	0				3,101			
3101		17	DRUGS-OTHER										3,110		-268,840	
3110		6	PT-PRIVATE	-268,840		0	0	0	0				3,111			
3111		6	PT-IPA			0	0	0	0				3,112			
3112		6	PT-MEDICARE PART A			0	0	0	0				3,113			
3113		6	PT-MEDICARE PART B			0	0	0	0				3,140			
3130		1	PUBLIC AID ASSESSMENT INC										3,150			
3140		19	LABORATORY INCOME			0	0	0	0				3,151			
3150		6	SPEECH/OT-PRIVATE			0	0	0	0				3,152			
3151		6	SPEECH/OT-IPA			0	0	0	0				3,153			
3152		6	SPEECH/OT-MED PART A			0	0	0	0				3,160			
3153		6	SPEECH/OT MED PART B										3,410		426,446	
3410		2	IPA DISCOUNTS	426,446		0	0	0	0				3,411			
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0				3,420			
3420		2	MEDICARE DISCOUNTS			0	0	0	0				3,500			
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0				3,520			
3520		16	RENT INCOME	0		6	0	6	0				3,530		-13,779	
3530		13	BEAUTY SHOP	-13,779		0	0	0	0				3,560		-1,858	
3560		12	ACTIVITY FUND INCOME	-1,858		0	0	0	0				3,570		366	
3570		12	VENDING INCOME/EXPENSE	366		0	0	0	0				3,590		-14,936	
3580		12	MANAGEMENT FEES			0	0	0	0				3,595		111	
3590		1	EQUIPMENT RENTAL	-14,825		0	0	0	0				3,600			
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0				4,110		91,578	
3600		21	MISC INCOME	0		0	0	0	0				4,111		54,041	
4110			GENERAL & ADMINIST WAGES	91,578	91,578	21	1	17	0				4,115			
4111			ADMINISTRATOR WAGES	54,041	54,041	17	1	0	0				4,120		73,512	
4115			VACATION & SICK - G&A	0		21	1	0	0				4,125			
4120	4475		EMPLOYEE BENEFITS	76,791	366,763	22	3	0	0				4,130			
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0				4,135			
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0				4,250		8,904	
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0				4,255		968	
4220			DIRECTORS FEES			18	3	0	0				4,260		14,652	
4250	4255		OFFICE SUPPLIES	12,425	12,638	21	2	0	0				4,275		1,999	
4260			TELEPHONE	14,652	14,652	21	3	0	0				4,276			
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0				4,280		241	
4280			GENERAL TRAVEL	241	3,544	24	3	16	0				4,281		43	
4281			MEAL EXPENSE FOR TRAVEL	43		24	3	19	0				4,285		3,180	
4285			EDUCATION & SEMINAR	3,260		24	3	19	-1,545	***			4,289		80	
4290			HELP WANTED ADVERTISING	3,287	102,795	20	3	0	0	-76,650			4,290		3,287	
4291			PROMOTIONAL ADVERTISING	8,153		20	3	25	-8,153				4,291		8,153	
4292			PUBLIC RELATIONS	5,835		20	3	25	-5,835				4,292		5,835	
4300			LICENSES & FEES	77,490		20	3	17	0				4,300		77,490	
4310			DUES & SUBSCRIPTIONS	7,715		20	3	17	-80				4,310		7,715	
4320			CONTRIBUTIONS	200		27	3	20	-200				4,320		200	
4350			PROFESSIONAL FEES	12,052	256,026	19	3	22	-538				4,350		12,052	
4355			MEDICAL DIRECTOR	600	600	9	3	0	0				4,355		600	
4360			UTILIZATION REVIEW	0		10	3	0	0				4,362		5,350	
4361			OTHER PHYSICIAN FEES			39	3	0	0				4,363		500	
4362			MEDICAL RECORDS CONSULT	5,350		10	3	0	0				4,364		6,657	
4363			PHARMACIST FEES	500		10	3	0	0				4,370		481	
4364			SOC SERV/ACT CONSULT	6,657	6,657	12	3	0	0				4,383		315	
4370			TV RENTAL	481		35	3	5	-226				4,390		1,300	
4380			INCOME TAXES	1,300	25,855	27	3	26	-1,300				4,400		158,366	
4383			BACKGROUND CHECKS	315		20	3	26	0				4,401		5,610	
4400			PAYROLL TAXES	158,366		22	3	0	0				4,410		105,047	
4401			PAYROLL TAXES ADMINIST	5,610		22	3	0	0				4,420		97,661	
4410			GROUP INSURANCE	105,047		22	3	0	0				4,430		26,200	
4420			LIABILITY INSURANCE	97,661	97,661	26	3	0	0				4,435		-5,251	
4425			INSURANCE-OWNERS			22	3	21	0				4,436			
4430			WORKMENS COMP INSURANCI	20,949		22	3	0	0				4,450		243,974	
4450			CENTRAL OFFICE FEES	243,974		19	3	34	0				4,460		24,943	
4460			BAD DEBTS	24,321		27	3	24	-24,321				4,461		-622	
4470			LOST ITEMS-RESIDENTS	34		27	3	0					4,470		34	
4490			MISCELLANEOUS			27	3	0	0				4,475		3,279	
4510			REAL ESTATE TAXES	0	0	33	3	0	0				4,486		2,052	
4600			LEASED EQUIPMENT	615	1,096	35	3	16	0				4,490		514	
5110			MAINTENANCE SALARIES	53,056	53,056	6	1	0	0				4,496		2,553	
5120			MAINTENANCE SICK & VAC	0		6	1	0	0				4,510			
5130			ELECTRIC	67,297	103,813	5	3	0	0				4,600		615	
5131			NATURAL GAS	16,508		5	3	0	0				5,110		53,056	
5132			HEATING & DEISEL OIL			5	3	0	0				5,120			
5133			WATER & SEWER	20,008		5	3	0	0				5,130		67,297	
5134			TRASH COLLECTION	4,866	32,772	6	3	0	0				5,131		16,508	
5140			PROPERTY PLANT REPLACEMN	4,462	44,556	6	2	0	0				5,133		20,008	
5160			GENERAL REPAIR & MAINT	40,094		6	2	0	0				5,134		4,866	
5165			MAINTENANCE CONTRACTS	27,906		6	3	0	0				5,140		4,462	
5210			DIETARY WAGES	267,146	267,146	1	1	0	0				5,160		40,094	
5220			DIETARY SICK & VAC	0		1	1	0	0				5,165		25,854	
5240			SALES TAX			2	3	13	0				5,210		267,146	
5248			FOOD PURCHASES	184,436	184,436	2	2	0	0				5,220			
5250			SUPPLIES-DISHWASHING	6,901	20,631	1	2	0	0				5,248		183,922	
5260			DIETARY REPLACEMENT	2,882		1	2	0	0				5,250		6,901	
5270			KITCHEN SUPPLIES-PAPER	10,848		1	2	0	0				5,260		2,882	
5295			MEAL CREDIT	0		2	2	0	0				5,270		10,848	
5310			LAUNDRY WAGES	68,583	68,583	4	1	0	0				5,295			
5340			LAUNDRY SICK & VAC	0		4	1	0	0				5,310		68,583	
5370			LAUNDRY REPLACEMENT	4,706	10,068	4	2	0	0				5,340			
5380			LAUNDRY REIMBURSEMENT			4	3	0	0				5,370		4,706	
5390			LAUNDRY SUPPLIES	5,362		4	2	0	0				5,380			
5410			HOUSEKEEPING WAGES	121,025	121,145	3	1	0	0				5,390		5,362	
5440			HOUSEKEEPING SICK & VAC	120		3	1	0	0				5,410		121,025	
5480			HOUSEKEEPING SUPPLIES	2,621	28,468	3	2	0	0				5,440		120	
5490			HOUSEKEEPING SUPPLIES-PPR	25,847		3	2	0	0				5,480		2,621	
6010			RN WAGES-MEDICARE		1,251,684	10	1	0	0				5,490		25,847	
6020			RN WAGES-NON MEDICARE	48,714		10	1	0	0				6,020		48,714	
6030			DON WAGES	62,975		10	1	0	0				6,030		62,975	
6035			ADON	19,366		10	1	0	0				6,035		19,366	
6040			RN SICK & VACATION	714		10	1	0	0				6,040		714	
6110			LPN WAGES-MEDICARE	0		10	1	0	0				6,120		372,985	
6120			LPN WAGES-NON MEDICARE	372,985		10	1	0	0				6,140		21,268	
6130			LPN WAGES OTHER			10	1	0	0				6,220		624,520	
6140			LPN SICK & VACATION	21,268		10	1	0	0				6,240		62,131	
6210			AIDE WAGES-MEDICARE			10	1	0	0				6,245		3,599	
6220			AIDE WAGES-NON MEDICARE	624,520		10	1	0	0				6,246		54,745	
6230			WARD CLERKS			10	1	0	0				6,247		74,891	
6240			AIDE VACATION & SICK	62,131		10	1	0	0				6,250		6,049	
6245			CONTRACT NURSES-RN	3,599		10	3	0	0				6,255		165	
6246			CONTRACT NURSES-LPN	54,745		10	3	0	0				6,260			
6247			CONTRACT NURSES-AIDES	74,891		10	3	0	0				6,270		37,099	
6250			NURSE AIDE TRAINING WAGES	6,049	6,049	13	1	0	0				6,275		1,912	
6255			NURSE AID TRAINING EXP	165	165	13	2	0	0				6,290		15,657	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0				6,295		80,472	
6270			REHAB WAGES	37,099		10	1	0	0				6,390		2,716	
6275			REHAB SICK & VAC	1,912		10	1	0	0				6,490		3,100	
6280			NURSING DEPT EDUCATION			23	3	0	0				7,280		49,645	
6290			NURSING SUPPLIES	15,657	98,845	10	2	0	0				7,281		-568	
6295			NURSING SUPPLIES	80,472		10	2	0	0				7,380		4,125	
6390			REPLACEMENT-NURSING	2,716		10	2	0	0				7,391		3,433	
6490			NURSING OTHER	3,100	142,185	10	3	0	0				7,393		805	
7280			DRUG PURCHASES	49,645	50,696	39	2	0	0	***			7,510		74,315	
7281			DRUG PURCHASES-OTHER	-568		39	2						7,540		347	
7380			LABORATORY SERVICES	8,363	135,293	39	3	0	0				7,590		5,849	
7410			HOME HEALTH SALARY			39	1	0	0				7,620		74,476	
7440			HOME HEALTH SICK & VAC			39	1	0	0				7,660		1,619	
7450			HOME HEALTH EXPENSES			39	3	0	0				7,710		27,092	
7510			ACTIVITES WAGES	74,315	74,662	11	1	0	0				7,720		1,404	
7540			ACTIVITIES SICK & VAC	347		11	1	0	0				7,730		44	
7590			ACTIVITIES SUPPLIES	5,849	5,849	11	2	0	0				7,740		47,062	
7595			ACTIVITIES FEES	0	0	11	3	0	0				7,750			
7610			PT WAGES			39	1	0	0				7,770		5,392	
7611			PT SICK & VACATION			39	1	0	0				7,820		8,730	
7620			PT FEES	74,476		39	3	0	0	***			7,890			
7660			PT SUPPLIES	1,619		39	2	0	0				7,960		213	
7710			SOCIAL SERVICE WAGES	27,092	28,496	12	1	0	0				8,120		3,066	
7720			SOCIAL SERVICE SICK & VAC	1,404		12	1	0	0				8,125			
7730			SOCIAL SERVICE EXPENSES	44	44	12	2	0	0				8,130		137,062	
7740			OT FEE	47,062		39	3	0	0	***			8,150			
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0				9,510		-4,615	3,254
7770			SPEECH THERAPY FEE	5,392		39	3	0	0	***			9,520		-9,106	
7800			BEAUTICIAN WAGES		0	40	1	0	0				9,530			36,057
7810			BEAUTICIAN SICK & VAC			40	1	0	0							
7820			BEAUTICIAN FEES	8,730	8,730	40	3	0	0						-168,410	
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0							
7910			VOLUNTEER COORDINATOR			21	1	0	0							
7940			VOL COORD SICK & VAC			21	1	0	0							
7960			VOL COORD SUPPLIES	213		21	2	0	0							
8100			RENT		0	34	3	0	0							
8120			INTEREST EXPENSE	3,066	3,066	32	3	14	-3,066							
8130			DEPRECIATION	137,062	137,062	30	3	9	5,019							
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	76,650						
9510			INTEREST INCOME	-4,615		32	0	10	0							
9520			MISC NON-OPERATING INCOM	-9,106		0	0	0	0							
9700			INCOME TAXES	0		0	0	0	0							
				3,899,684	3,913,405											
					13,721											
GRAND TOTALS				-168,410					-40,245							
				(NET INCOME)												
				0												

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL: 0
173,113

	G/L	RECAP CENSUS
PP	17,502	17,305
IPA	17,850	17,850
medicare	2,444	2,444
		37,599

IPA BEDHOLDS	0
PP BEDHOLDS	197
PP CONVERS	0